When health and police sectors collaborate to improve access to mental health care: a qualitative study on the implementation of a mixed healthcare and police team

Lorsque les milieux de la santé et policiers collaborent pour faciliter l'accès aux soins en santé mentale: une étude qualitative

Abstract:
Police interventions involving mental health issues remains arduous. Through 15 qualitative interviews with police officers and healthcare providers, the study aims to describe a mixed healthcare and police intervention model and to explore implementation strategies. Findings highlights the model's capacity to outreach to otherwise shunned mental health patients. Key challenges include navigating confidentiality and organizational constraints such as workforce shortages. Despite promising data, sustainability and transferability require structural support beyond individual commitment. This study offers insights for scaling up intersectoral mental health interventions aimed at reducing coercion and improving care access in community settings when there is no immediate emergency.

Les interventions policières liées à la santé mentale demeurent complexes. À partir de 15 entretiens qualitatifs auprès de policiers et d'intervenants, cette étude décrit la mise en œuvre d'une équipe d'intervention mixte en santé mentale et policière. Les résultats soulignent sa capacité à joindre des personnes désaffiliées du réseau de la santé. Les défis concernent la confidentialité, les contraintes organisationnelles et la nécessité d'un soutien structurel car sa mise en oeuvre ne peut reposer que sur l'engagement de l'équipe. L'étude offre des pistes pour une mise à l'échelle d'interventions intersectorielles visant à améliorer l'accès aux soins.

Keywords:
mental health, police officers, intersectoral collaboration, qualitative, implementation
santé mentale, policiers, collaboration intersectorielle, étude qualitative, mise en oeuvre

Background

In Canada, it is estimated that up to 31% of police interventions involve individuals with mental health disorders, representing substantial economic and human resource costs (Coleman & Cotton, 2010). Concerns related to dissatisfaction with police interventions, disrespectful and threatening interactions, and the use of force by police officers have been identified as significant issues (Evangelista et al., 2016). In such situations, repeated use of involuntary hospitalizations increases the risk of morbidity and mortality among individuals in crisis (Marcus & Stergiopoulos, 2022). From the perspective of law enforcement, access to crisis intervention services remains complex. In recent years, various stakeholders from the healthcare system, law enforcement, and community organizations have highlighted the healthcare and social services system's inability to effectively support individuals experiencing acute mental health distress.

In this context, two main models have been developed to improve crisis outcomes (Marcus & Stergiopoulos, 2022). The first is the Crisis Intervention Team (CIT) model (Kisely et al., 2010; Shapiro et al., 2015), in which police officers receive specialized training in crisis management and have access to a mental health team for rapid liaison. The second model, often referred to as the co-response model, involves police officers working directly alongside mental health professionals as part of a joint response team (Puntis et al., 2018). These intersectoral approaches involve police officers working collaboratively with mental health professionals to respond to crisis situations in the community (Balfour & Zeller, 2023). Such interventions have been shown to reduce the use of force, injuries (Shapiro et al., 2015), arrests (Puntis et al., 2018), and unnecessary involuntary detentions (Heffernan et al., 2024). They also facilitate increased referrals to community and healthcare services (Shapiro et al., 2015), enhance coordination and collaboration between law enforcement and mental health services (Puntis et al., 2018), promote engagement in mental health follow-up (Kisely et al., 2010), and improve satisfaction among intersectoral teams and patients (Puntis et al., 2018).

Both models are currently in place in Montreal (Quebec, Canada). The availability and composition of teams varies by territory. Each police precinct has several CIT-trained RIC *(Réponse en intervention de Crise)* patrol officers who serve as first responders during crisis (SPVM, 2021). The entire island is covered by ÉSUP (*Équipe de soutien aux urgences psychosociales*), a co-response model that includes police officers, social workers, and a clinical coordinator. Police can also contact non-police crisis teams such as *Urgences psychosociale-justice* which generally respond only after police assessment and focus on psychosocial follow-up (CIUSSS du Centre-Sud-de-l'Ile-de-Montreal, 2021). These existing models primarily target acute emergencies with imminent risk of harm, aiming to ensure safe transport to the emergency department and prevent arrest. However, many police encounters involve individuals with severe disorganization or distress who do not meet criteria for arrest or involuntary admission (Shore & Lavoie, 2019), leaving a service gap. The proposed model addresses this by offering joint interventions to manage these cases proactively and reduce unnecessary police involvement and hospital admissions.

The success of joint mental health and police intervention teams depends on the availability of psychiatric services for officers, active engagement, a clear understanding of each stakeholder's role, and a strong partnership between law enforcement and mental health services (Kane et al., 2018). Such a partnership has been established between three police stations of the Service de police de la Ville de Montréal (SPVM) and the primary care adult mental health team serving the corresponding territories in the eastern region of Montreal. Since January 2022, these stakeholders have implemented an innovative joint intervention model, the ECHINOPS team (**É**quipe **C**ommunautaire **H**ybride d'**I**nterventions **N**ovatrices **O**BNL **P**sychiatrie **S**PVM). ECHINOPS is embedded within *Quebec's 2022-2026 Interministerial Mental Health Action Plan*, which prioritizes the implementation and consolidation of joint psychosocial and community-based police interventions (Gouvernement du Québec, 2022). While the government explores the possibility to scale up implementation, limited data is available regarding the challenges of deploying such teams and the specific populations they serve.

The aim of this study is to describe the ECHINOPS mixed healthcare and police intervention model and to explore implementation strategies from the perspectives of mental healthcare providers and police officers.

Methods

This qualitative study on the implementation of the ECHINOPS team from healthcare and police perspectives is part of a larger participatory mixed-methods project on ECHINOPS, which received ethical approval from the CIUSSS de l'Est-de-l'Île-de-Montréal (project number 2024-3484). It uses an exploratory qualitative design and is supported by a multidisciplinary advisory committee composed of researchers, mental healthcare providers (psychiatrist, nurses, and residents), a mental health advisor from the police sector, a representative from a mental health user advocacy association, and patient partners from a non-profit community organization specializing in schizophrenia. The study protocol was developed in collaboration with the research team and discussed with the patient partners to validate the research questions and interview guides. In 2025, the research team is collecting data for the quantitative component, as well as service user perspectives specifically focused on the perceived outcomes of the ECHINOPS team.A purposive sampling approach was used to recruit 7 police officers (including police officers and community relations police officers) and 8 mental healthcare providers (nurses, psychiatrist, and managers). The primary inclusion criterion was having been a member of the ECHINOPS team or having been significantly involved in the project within the past six months. The information and consent form was explained to participants, and their written informed consent was obtained prior to data collection. Semi-structured individual interviews were carried out by a nursing graduate student with lived experience of a mental health crisis (Hudson & Beames, 2025). Recorded interviews took place in person in a private room at the participant's workplace, except when an online interview via Microsoft Teams was requested. The interviews lasted 54 minutes on average, with a range between 39 and 71 minutes.

The interview guides were developed based on the principles of procedural justice theory (Lind & Tyler, 1988) and the implementation science indicators identified by Proctor et al. (2011). Procedural justice theory, originating from social psychology, is widely used in the field of law enforcement and has more recently been applied to mental health practice (Lessard-Deschênes et al., 2024). It examines the perceived fairness and equity of social processes involving authority figures. Its core principles include voice, neutrality, respect, and trust. Implementation indicators encompass acceptability, adoption, appropriateness, feasibility, fidelity, penetration, and cost (Proctor et al., 2011), as well as sustainability and transferability. Additionally, specific questions related to the ECHINOPS team were explored. Two examples of questions asked are: (1) In your opinion, is the ECHINOPS model acceptable in your professional practice? How?; (2) Do you think the team is following the ECHINOPS model as it was originally proposed? Why or why not?"

After recording, the interview data were transcribed using Sonix.AI, where transcripts were anonymized, and managed and analyzing using Microsoft products (Word, Excel). The data were coded and condensed through content analysis, following the

steps of identifying meaningful segments, preliminary coding, and coding (Miles et al., 2014). The coding process was both deductive, to align with Proctor's implementation framework, and inductive, to remain sensitive to emergent themes raised by participants. Intra- and inter-group differences and similarities (police officers and healthcare providers) were analyzed and then presented to the research team for discussion of potential interpretations.

Results

The results first provide a description of ECHINOPS team and its interventions, followed by the indicators related to its implementation.

1. Description of the ECHINOPS team

All participants have a similar understanding of the team's purpose and function: to facilitate access to mental health services, including psychiatric assessment, for people in contact with law enforcement who are experiencing significant mental distress and need help but who are not a danger to themselves or others. These situations often involve individuals or their carers making repeated 911 calls for issues such as noise complaints, psychosocial problems, or severe disorganization, creating a heavy workload for officers and highlighting a lack of proper care coordination. While the range of circumstances is broad, participants emphasized this pattern of repeated, non-emergency calls as a key target for the team's intervention.

We receive recurring calls from individuals who are not necessarily committing crimes but who suffer from mental health issues and have the right to call 911 because they genuinely feel human distress and perceive a danger to their lives. However, in reality, there is no actual danger. PO4

The initiative began in 2019 with community relations police officers (CRPOs) from two police stations who reached out to a community health center to explore potential service options and collaboration strategies. A key challenge emerged: many patients were reluctant to seek care at the community mental health center, so they proposed an innovative solution by providing home-based care. The ECHINOPS team was formalized in 2020 leading to its integration into the healthcare system.

When we saw how well it worked and how receptive the person was in their own environment, we thought, "My God, we've found an approach that really works for them." So we started seeing more people, and after a few months, it snowballed to the point where we realized we needed to structure things because it was getting big—people were really interested, it was working well, and everything was coming together. PO2

The healthcare team (see Table 1 for respective roles) collaborates with police services to act as consultants and to implement and strengthen integrated healthcare. Four guiding principles shape this initiative:

a) A structured partnership between law enforcement and the healthcare system.
b) Proactive measures taken before a mental health crisis occurs to enhance engagement with mental health services.
c) Evaluation and follow-up for individuals who do not actively seek these services.
d) Prevention of emergency room visits.

This population is on the margins of the system, they don't trust the system, and because of their illness, they don't want to enter the system. These are the patients we are reaching out to. We are engaging with a group that otherwise wouldn't receive services, or they would only access care through the emergency department—meaning through a coercive approach. HCP1

Figure 1 illustrates the possible care pathways. A key feature that differentiates ECHINOPS from other mixed intervention teams in Québec its focus on outreach and the support provided by the mental health team to the police officers and. CRPOs and mental health providers hold weekly meetings to coordinate efforts and discuss cases, evaluations, and interventions. Additionally, a nurse visits participating police stations several times a month to engage with police officers and address their questions.

Figure 1. Trajectory of cases

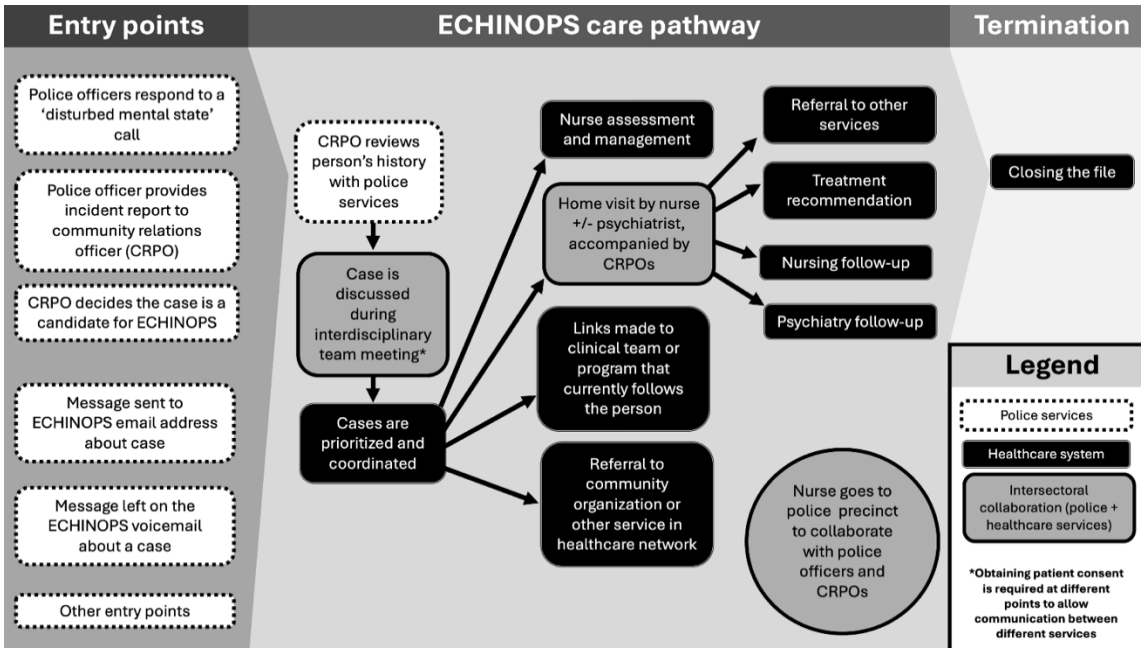

Table 1. Description of Team Members' Roles

Role	Description
Police officer	- First responders to 911 calls and initial assessment - Decision-making and police intervention: arrest; forced transport to ED for danger to self or others; call crisis team; no immediate police intervention (*this is ECHINOPS clientele*) - Write report (disturbed mental state); contact CRPO for referral to ECHINOPS
Community relations police officer (CRPO)	- In charge of mental health files for their police station - Bridge between law enforcement and the healthcare system by coordinating with HCP and community organisations - Connect with clientele to offer service, to ensure consent is signed - Make the first contact during the intervention: explain why the team is there and their roles - Ensure security during the intervention (at least 2 police officers attend clinical intervention) - Education and knowledge transfer

Nurse	- Assess referrals - Investigate history through medical files to see if they have active clinical follow-up - Make liaison with their clinical team if needed - Intervene with ECHINOPS patients - Coordinate with ECHINOPS team: before meeting with patient discusses case and potential care trajectory with team - Initial clinical assessment and clinical decision-making - Reaches out to clients to provide follow-up if needed - Intersectoral collaboration with CRPOs - Education and knowledge transfer
Psychiatrist	- Meet with a portion of patients - Clinical evaluation and decision-making - Managing care if needed: prescribe medication, refer to services, follow-up appointment - Interprofessional and intersectoral collaboration - Education and knowledge transfer
Administration healthcare (from high level to daily operation level)	- Develop the ECHINOPS guideline: clarify roles, overcome initial obstacles - Coordinate operations within the healthcare system and with law enforcement - Manage personnel and healthcare team - Administrative follow-up of the trajectory of the patient - Collect and analyze data

2. Themes related to the implementation of ECHINOPS

Seven sub-themes from Proctor's implementation outcomes (acceptability, adoption, appropriateness, cost, feasibility, fidelity, and penetration) as well as two additional sub-themes identified through analysis (sustainability and transferability) are discussed by the participants.

2.1 Acceptability

There is a strong perception among participants that ECHINOPS is a highly acceptable model, enhancing both their sense of usefulness and job satisfaction. CRPOs repeatedly mentioned they would not want to return to previous practices. Participants also agreed that the model fits their professional roles and competencies. Police officers highlighted that ECHINOPS generates interest among colleagues from other police stations. On the healthcare side, the outreach approach was identified as a key element supporting the model's acceptability.

"It is probably, in my whole week, the moment when my professional skills are most fully engaged, because everything is there — the patient's real-life context. You see the patient in their everyday reality. It's like all your senses are awakened, and you learn so much more about the person." (HCP1)

A challenge was identified related to ethical concerns about equity. I8 mentioned that, from a management perspective, it can be difficult to prioritize prevention and outreach for individuals not actively seeking services when teams are already struggling to manage waitlists for specialized care. This raises the question whether the mechanism underpinning the ECHINOPS team might unintentionally favour certain individuals by bringing them to the front of the line to access mental health care.

2.2 Adoption

Most participants joined the team because the approach made sense and aligned with the challenges they faced in their daily work, both in policing and in healthcare. According to participants, the project addresses critical gaps in mental health care and improves access to services by fostering collaboration between law enforcement and healthcare providers, making their work more meaningful and satisfying.

"This collaboration between the two organizations is truly remarkable. We realized that we often work with the same people, the same clients, but without coordination or teamwork. Now, part of the work we do is sometimes done by police officers when they interact with these individuals. I think the real added value is this partnership and the new fluidity we have in communicating and coordinating our efforts to help a person." (HCP2)

The main perceived benefits for police participants include a reduction in repeated calls, workload, emergency transports, hospitalizations, criminalization, and entry into the judicial system. On the healthcare side, improvements were noted in access to mental health services, intersectoral and interdisciplinary collaboration, and a better understanding of the roles, work, and professional scope of practice of other team members.

However, adoption required considerable effort from CRPOs to engage teams, promote understanding of the model, and ensure its integration, specifically with the police officers who have a critical role since they refer cases to the CRPOs. These efforts are necessary due to the frequent arrival of new officers and internal transfers, underscoring the need for persistent advocacy to keep the project at the forefront of the officers' minds.

Organizational adoption was attributed to the fact that mental health-related calls represent a significant portion of police work, and managers recognized the benefits of the project, leading to formal agreements and broader recognition.

2.3 Appropriateness

Most participants perceived that ECHINOPS effectively meets the needs of individuals who do not actively seek mental health services. Participants emphasized that this model allows for more personalized care and consistent follow-up, in contrast to the fragmented nature of traditional emergency responses. Observing people in their living environment also helps better understand their needs and may reduce the use of coercion.

Most participants highly valued the rapid access to a psychiatrist and a nurse, facilitating timely interventions such as prescribing medication or directly linking people to other services. This contrasts with other teams, which often still rely on referrals to primary care, leading to long waitlists. Some participants noted potential overlap with other crisis response teams in the area, highlighting the importance of clarifying each team's role and scope to optimize resource allocation.

ECHINOPS is viewed as flexible and adaptable to diverse situations and populations, particularly those who are distrustful of the healthcare system or without a family doctor. However, engaging these individuals remains challenging and requires building trust and respecting privacy through sensitive and strategic approaches. Illustrating this concern, one

police officer participant explained: "*When the nurse or psychiatrist comes, you can't really tell who they are, obviously. But we're in uniform, so that draws more attention, like it or not. Otherwise, it really does match the clientele perfectly. It's an all-inclusive service: we go to them, we offer, we listen, we try to help. So in terms of fit, I think it really meets what people want. I'm sure if we offered it to more people, many would say yes, because they don't want to travel or be seen at the CLSC, or go to psychiatry—it just feels too big to them to go to the ER for psychiatric help. So on that level, it meets all the needs."* (PO7)

2.4 Costs

Another facilitating factor was the decision to align the structure of the intervention as closely with the organization's existing administrative care pathways for accessing mental health services. This approach allowed the project to operate without requiring additional funding. However, one manager emphasized that ensuring the long-term sustainability of ECHINOPS would require dedicated financial resources. When budget cuts were imposed, the nursing position responsible for coordinating referrals within the ECHINOPS team was eliminated after three years of operation. Moreover, several participants noted that shifting political priorities could influence resource allocation and affect institutional commitment to implementing the ECHINOPS model: "*it could be another government at some point that comes in and says, "I don't believe in mixed teams," and that's the end of it. That would be it, I think.*" (HCP4)

2.5 Feasibility

Participants generally reported that the model was successfully implemented within a primary care mental health setting and two neighbourhood police stations, integrating into existing structures. Among the key facilitators supporting its feasibility, the participatory approach — through the establishment of a broad committee involving all stakeholders — was frequently mentioned. However, participants also noted the complexity and lengthy process required to formalize agreements between services and to develop an intersectoral protocol.

Furthermore, navigating the complex bureaucratic processes within large organizations such as the police and the healthcare system have slowed down or even halted implementation in several areas. The project requires substantial time investment, which some managers perceive as an additional burden. Effective implementation is further challenged by the need for directives from higher-level management to ensure consistent prioritization across different police stations. Several participants highlighted the need for strengthened intersectoral collaboration to enable police precincts and community health centres to better coordinate and sustain these services.

One of the most frequently reported challenges relates to the lack of human resources and the difficulty of training new staff. These limitations have hindered efforts to expand ECHINOPS to additional neighbourhood police precincts. In one case, the retirement of a CRPO left the project without a replacement, forcing the suspension of activities in that area. *"Unfortunately, there aren't 50 psychiatrists, and there aren't 50 police officers like us either."* (PO4). This situation highlights the precariousness of the model: the departure

or the absence of a single key actor, whether a CRPO, nurse, or psychiatrist, can interrupt service delivery.

Furthermore, differences in the scope of practice between healthcare providers in various sectors were identified as barriers. While the community psychiatrist involved in ECHINOPS provides home visits, this option is not available in other sectors where psychiatrists do not perform this role. Similarly, nurses do not have the same responsibilities across sectors. These contextual disparities and the complexity of healthcare organizations challenge the transferability and feasibility of the model, underscoring the need for improved workforce planning and organizational flexibility.

2.6 Fidelity

The protocol was modified in the first few months to comply with legal requirements regarding the consent of individuals encountered by the ECHINOPS team and to optimize care pathways. The main modification involved requiring service users to sign an authorization to disclose identifying and medical information before CRPOs were allowed to share their information.

"The whole issue of confidentiality was definitely the most challenging one. How do we ensure informed consent from users? When and how are we allowed to share information, and when are we not? So all those procedures had to be clarified." HCP4

However, despite this modification, confidentiality and information exchange between services remains a challenge due to the strict legal requirements regarding information access. Without this signed authorization, CRPOs cannot share information about service users with the care team, complicating intervention planning. Some participants questioned this, even wondering whether the lack of information could put healthcare providers at risk.

2.7 Penetration

Many participants felt that the ECHINOPS team was well integrated into the community and able to reach enough individuals. However, they acknowledged that many potential clients would never reach out to police or health services, remaining beyond the team's reach, particularly given its limited resources. Police officers remain the primary point of entry, but participants expressed a desire for stronger integration with local service networks. Expanding the program to additional police precincts and enhancing collaboration with community organizations were suggested to reach a broader population, including child and adolescent psychiatry.

"We could strengthen our connections with intersectoral partners. I think there is still a lot of work to be done within our teams in this regard." (HCP3)

2.8 Sustainability

The ECHINOPS model was viewed by all participants as essential and indefinitely necessary, highlighting its perceived importance, although some acknowledged that the model may evolve over time. Per PO4: *"I hope it lasts forever. Listen, if it doesn't continue,*

I'd really question our social priorities. It wouldn't make any sense. And I'd say it should also serve youth. I'd even go so far as to say it should go down to twelve years old. It has to continue—otherwise I'll freak out, it wouldn't make any sense."

To ensure its sustainability, participants suggested that ECHINOPS should be embedded as a priority in both the action plans of police precincts and the healthcare system. In this regard, it was proposed that governmental protocols should be developed and adequately funded, with potential risks related to sudden budget cuts or shifts in political leadership.

Facilitators of ECHINOPS' sustainability include the team's strong motivation and transparency. Participants highlighted individual initiatives, such as creating shared tracking tools to ensure service continuity and support succession planning. However, many noted that this responsibility should primarily lie with organizations and managers.

2.9 Transferability

All participants believed that the ECHINOPS model should be scaled up. Many felt that, since the model is integrated within existing mental health services and operates with limited additional resources, it could be adapted to various settings. The two main areas where ECHINOPS was implemented present very different sociodemographic profiles (age, socioeconomic status, immigration, substance use), reinforcing the perception of its potential adaptability. However, some participants questioned whether integrating the project within existing structures is truly sustainable.

"I wish it had spread everywhere, but these were additional tasks to our regular work. And I didn't have anyone assigned to support me in this role. We had to organize ourselves, share tasks, and fit everything in. So I think it's just about figuring out how it works. But when people are less motivated or aren't champions of the project, it just falls apart." (PO3)

One key factor supporting transferability lies in the presence of local project champions, considered essential to demonstrating the model's relevance and mobilizing resources. However, participants emphasized that relying solely on the motivation and commitment of a few individuals is unlikely to ensure long-term sustainability, particularly in other settings. While this strategy may be viable in the short term, the absence of structural and organizational support may lead to recurring barriers over time. Other barriers to transferability were identified, notably resistance from some physicians and nurses to conduct home visits, the lack of human resources, and operational differences across healthcare organizations.

To successfully scale up, participants emphasized the importance of overcoming resistance by demonstrating concrete benefits, adapting available human resources, and standardizing practices across different structures to ensure consistent implementation. Generating empirical evidence to document the model's positive outcomes was viewed as critical to support broader implementation.

Table 2. Implementation Challenges and Facilitators of ECHINOPS

Implementation Indicator	Main Challenges	Facilitators

Acceptability	Ethical concerns about equity; balancing outreach for non-service users vs. limited resources	High perceived usefulness and job satisfaction; alignment with professional roles
Adoption	Need for repeated explanations, and materials to ensure police officers engagement	An intervention making sense with the challenges faced; intersectoral collaboration
Appropriateness	Potential overlap with other teams	Flexible model; home-based care; rapid access to psychiatrist and nurse; personalized interventions
Costs	Vulnerability to budget cuts	Integration into existing care pathways; initial implementation without extra funding
Feasibility	Complex bureaucracy; time-consuming agreements; staff turnover; limited resources	Participatory approach; early involvement of all stakeholders
Fidelity	Strict confidentiality laws; complex consent procedures delaying information sharing	Protocol adaptations to comply with legal requirements
Penetration	Desire to expand collaboration with community organizations	Ability to reach a sufficient number of individuals
Sustainability	Dependence on few local champions; to be integrated in local and provincial action plans for both police and health services	Strong team motivation; transparency; shared tracking tools for continuity
Transferability	Variability in professional scopes; willingness to do home-based care; context-specific practices	Demonstrating concrete benefits; adapting human resources; standardizing practices across sectors

Discussion

This study aimed to describe and explore the implementation of the ECHINOPS model from the perspective of its team members. Findings highlight the perceived potential of this model in addressing service gaps for individuals in mental distress and the complex conditions required to ensure its successful implementation, sustainability, and potential transferability.

Addressing a critical service gap. The ECHINOPS model appears to directly respond to well-documented limitations of existing crisis response systems, particularly for individuals with significant mental health issues who do not meet the acute criteria for emergency intervention but still require support. Consistent with prior research on non-law enforcement-based response models and law enforcement-based response models (Compton et al., 2024; Fisher et al., 2024), ECHINOPS was perceived by both police and healthcare providers as highly appropriate and acceptable, with its outreach approach seen as a critical feature for engaging hard-to-reach populations. Participants repeatedly emphasized the added value of home-based interventions, which allow for a better understanding of the individual's needs, context, and resources. This finding resonates with Bakko's (2025) study, identifying that mobile crisis responses were found to effectively

achieve key crisis intervention objectives by resolving crises informally or without hospitalization, facilitating connections to community services, and ensuring appropriate follow-up care.

Importantly, the model also contributed to improving collaboration between police and mental health services, addressing a longstanding challenge in crisis management (Hudson et al., 2024). The structured partnership, regular meetings, and knowledge exchange between sectors contributed to dismantling professional silos and enhancing intersectoral coordination.

Although the literature often emphasizes the disparities between mental health and police services, our study found that both sectors face many of the same barriers to implementation: limited human and financial resources, organizational constraints, challenges related to information sharing and confidentiality, and the need to formalize agreements and protocols. However, their implementation experiences diverge in important ways. These include shifting professional roles—such as the variable scope of practice for nurses and psychiatrists across healthcare settings, compared to the more standardized role of CRPOs—and differences in referral processes. CRPOs manage referrals from multiple sources and must actively maintain relationships with patrol officers to sustain referrals, while HCPs receive cases exclusively from CRPOs.

Strengths and key success enablers. Several factors were identified as critical to the successful implementation of ECHINOPS. First, the participatory approach adopted, including the involvement of a broad range of stakeholders, fostered shared ownership of the project and contributed to role clarification and trust-building. This finding aligns with best practices in implementation science, which emphasize the importance of co-design and stakeholder engagement (Potthoff et al., 2023).

Second, the role of project champions emerged as a critical enabler of implementation. In both police and healthcare settings, highly committed individuals were instrumental in promoting the model, addressing initial resistance, and supporting their colleagues in adopting new practices. This finding aligns with previous studies highlighting the influential role of local champions in driving implementation and fostering organizational change (Greenhalgh et al., 2004). However, it is important to reflect on the sustainability of complex interventions that rely heavily on individual champions. As noted in a recent review, the departure of key champions can disrupt intervention momentum, and without structural or institutional support, the long-term viability of such initiatives may be compromised (Astorino Nicola et al., 2024). While the model's integration into existing services and its reliance on current personnel were initially perceived as facilitating factors, these same features may limit its scalability and long-term viability. As several participants noted, embedding ECHINOPS as an explicit organizational priority — supported by dedicated funding and policy directives — is likely necessary to secure its future.

Implementation Barriers and Areas for Improvement. Despite its perceived strengths, the implementation of ECHINOPS faced several barriers, many of which have implications for other jurisdictions seeking to replicate similar models.

Organizational complexity and bureaucratic processes within both police and healthcare systems emerged as significant barriers to implementation. Navigating these institutional structures demanded significant time and coordination, particularly in establishing formal agreements and clarifying procedures for information-sharing protocols. A persistent issue was the tension between legal requirements related to confidentiality and the operational needs of collaborative interventions. This underscores the importance of establishing clear, standardized procedures that ensure both ethical and effective communication. These findings align with those of Steden (2020), who noted that although stakeholders expressed openness toward intersectoral collaboration, confidentiality concerns and the absence of formalized structural partnerships often hindered its success. Similarly, Fisher et al. (2024) emphasized the cultural differences between law enforcement and mental health services as a barrier to implementation. However, they found that information-sharing agreements and program compatibility with existing services were key enablers of implementation.

The sustainability and scalability of ECHINOPS are further challenged by workforce limitations. Participants emphasized that the departure or absence of a single key actor can significantly disrupt service continuity. These human resource constraints, compounded by the time-intensive nature of intersectoral collaboration, underscore the importance of organizational investment and strategic workforce planning to ensure long-term viability. Similar findings have been reported in recent literature: Lambiase (2024) identified critical gaps in the availability of both human and material resources as major obstacles to effective law enforcement and mental health crisis responses, while McGuier et al. (2024) emphasized that staffing shortages and workforce turnover directly hinder the implementation and sustainability of such collaborative interventions. . Strategies to maintain service continuity could include cross-training additional staff, fostering communities of practice, and building institutional memory through shared tools and documentation. Importantly, sustainability cannot rely solely on the goodwill or exceptional commitment of a few individuals; structural supports must be in place to ensure resilience over time.

Finally, participants raised concerns about equity and the potential unintended consequences of prioritizing individuals identified by police, which may result in bypassing existing mental health service waitlists. This ethical tension warrants careful reflection, particularly in contexts where resources are limited, and access to care is already constrained. Moreover, these interventions often involve individuals with complex needs requiring intensive intersectoral coordination. As Karam et al. (2023) note, "the homogeneity or heterogeneity of patients' complex needs shapes their care trajectory and the intensity of their care coordination needs. As the complexity of these needs grows, so does the necessity to build the care coordinators' capacity for integrated care." In this context, individuals targeted by outreach may follow a care trajectory that diverges from traditional access points in the mental health system. To address these challenges, some scholars advocate for prioritizing more recent referrals, which may be more clinically and ethically appropriate in situations of limited capacity (Haustein et al., 2024).

Transferability and Future Directions. Participants generally believed that the ECHINOPS model could be adapted to other settings, given its integration within existing mental health services and its flexibility. However, transferability is contingent on local contexts, particularly regarding the availability of community psychiatry and the scope of nursing

practice, which vary considerably across regions. Scaling up this model will therefore require careful consideration of these contextual factors, as well as investment in developing local champions and fostering intersectoral partnerships. Demonstrating the model's effectiveness through empirical data — including patient-reported experience measures (PREMs), patient-reported outcome measures (PROMs), reduction in emergency visits, and cost-effectiveness analyses — will be essential to support broader adoption within a learning health system.

Recommendations for Practice

Based on the findings of this study, the following recommendations can guide the future development, sustainability, and scalability of outreach-based police–mental health partnerships such as ECHINOPS:

1. Collaboration and structural integration
    - **Leverage outreach-based models to address service gaps**: Programs like ECHINOPS are particularly well suited for engaging individuals with complex needs who do not actively seek care.
    - **Support structural integration collaboration**: Ensure that organizational frameworks promote interprofessional and intersectoral partnerships, clarify roles, and support safe and ethical information sharing
    - **Enhance partnerships with the community**: Deepen collaboration with community organizations and other local services to improve continuity, integration, and responsiveness of care.
2. Sustainability and workforce development
    - **Broaden the range of professionals involved**: Expand teams to include peer support workers, social workers, and specialized mental health nurse practitioners, especially in sectors lacking community-based psychiatrists.
    - **Ensure institutional commitment and resource allocation**: These models must be embedded within institutional policies and priorities, and supported by dedicated financial and human resources.
    - **Plan for retirement and workforce development**: Develop structured mechanisms to train, support, and retain staff to ensure long-term service continuity and reduce vulnerability to turnover.
3. Implementation and scale-up
    - **Balance flexibility and standardization**: Effective scaling requires a dual approach: flexibility to adapt to local contexts and standardization of key practices to ensure fidelity, accountability, and quality of care.
    - **Develop clear operational guidelines**: Formalize shared protocols and clinical pathways to aligned and consistent practices across sectors.
4. Learning and evaluation
    - **Build a learning health system**: Establish routine data collection and data systems to support quality improvement, and inform decision-making.

Limitations

This study has several limitations typical of qualitative research. The findings are context-specific and may not be transferable to other settings or populations. Although the sample

size was suitable for an exploratory qualitative design and comprised the totality of people who have worked on ECHINOPS, it may not reflect the full range of experiences. The data are based on self-reported perceptions, which may be subject to recall or social desirability bias (Althubaiti, 2016); however, ECHINOPS team members were not involved in the analysis, which may have helped mitigate this bias. Lastly, the absence of service user perspectives limits the scope and depth of the findings. Future research should actively engage individuals with lived experience of mental health issues who have interacted with the ECHINOPS team. Capturing their views, particularly regarding perceptions of coercion, trust, and engagement, is essential to ensure that any future scale-up of this innovative collaboration aligns with the needs, preferences, and expectations of service users themselves.

Conclusion

This study contributes to the growing body of knowledge on mixed police and mental health interventions designed to improve crisis responses for individuals with significant psychological distress who do not meet emergency criteria. Overall, the findings of this study help support and guide the scaling up of this type of intervention by providing a clearer understanding of the enablers and barriers to its implementation. Such intersectoral collaboration—uniting the efforts of police services, mental health providers, community organizations, and researchers—contributes to the development of a learning health system and helps break down silos. Within this framework, the ECHINOPS project can foster the advancement and transferability of leading practices in mental health care through the evaluation and recognition of field-based data.

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